Community Care of North Carolina

ACCESS II & III

PRESENTATION:
NC Medicaid Reform
"Improving Quality While Controlling Cost"

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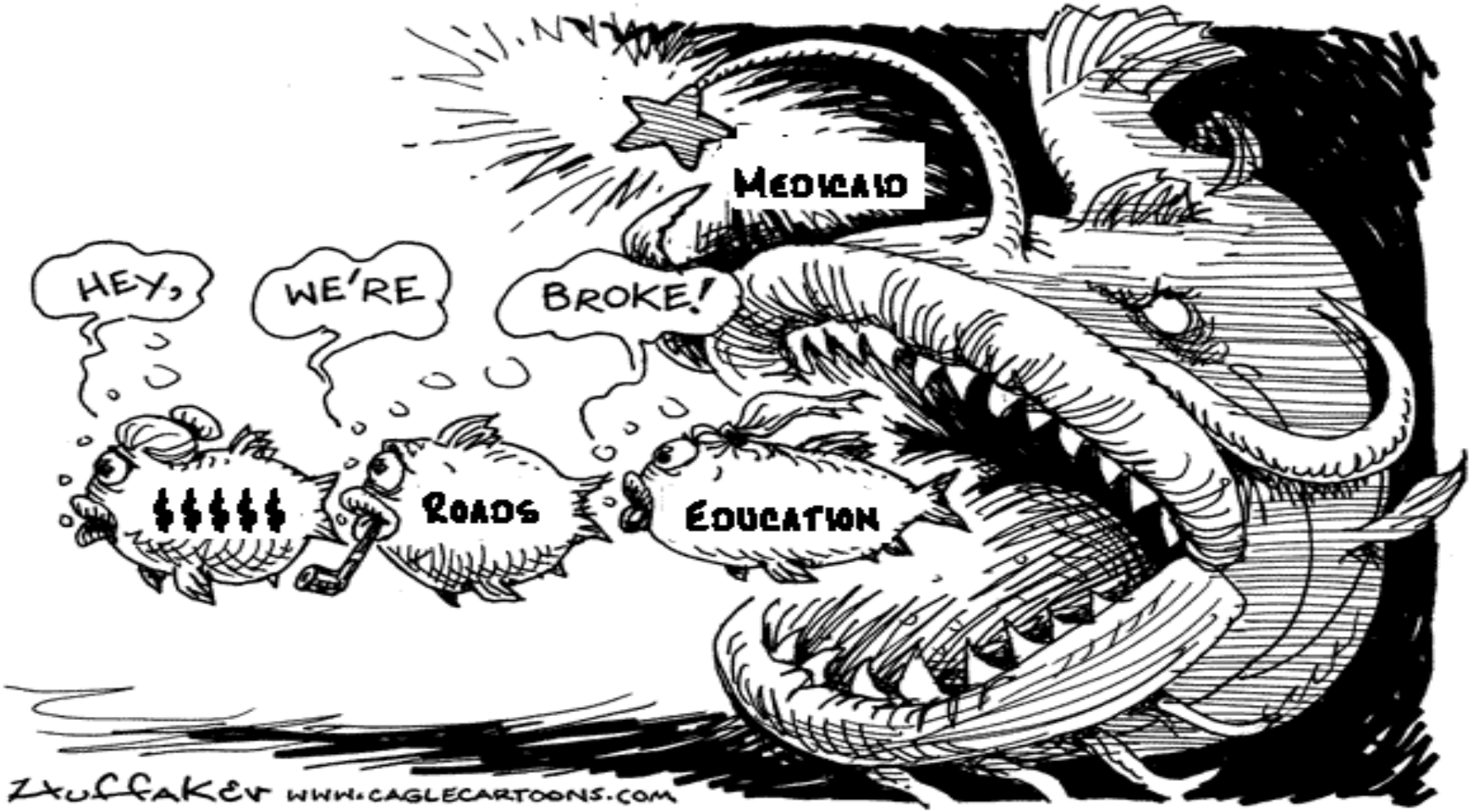
Human Services


MEDICAID
HEY,
WE'RE
BROKE!
$$$$$
ROADS
EDUCATION
ZUFFAKER WWW.CAGLECARTOONS.COM

Objectives

- General problems facing State Medicaid Programs
- Community Care of NC- our experience and what led us to our current program
- Discussion of ongoing initiatives and results
- A few take home thoughts

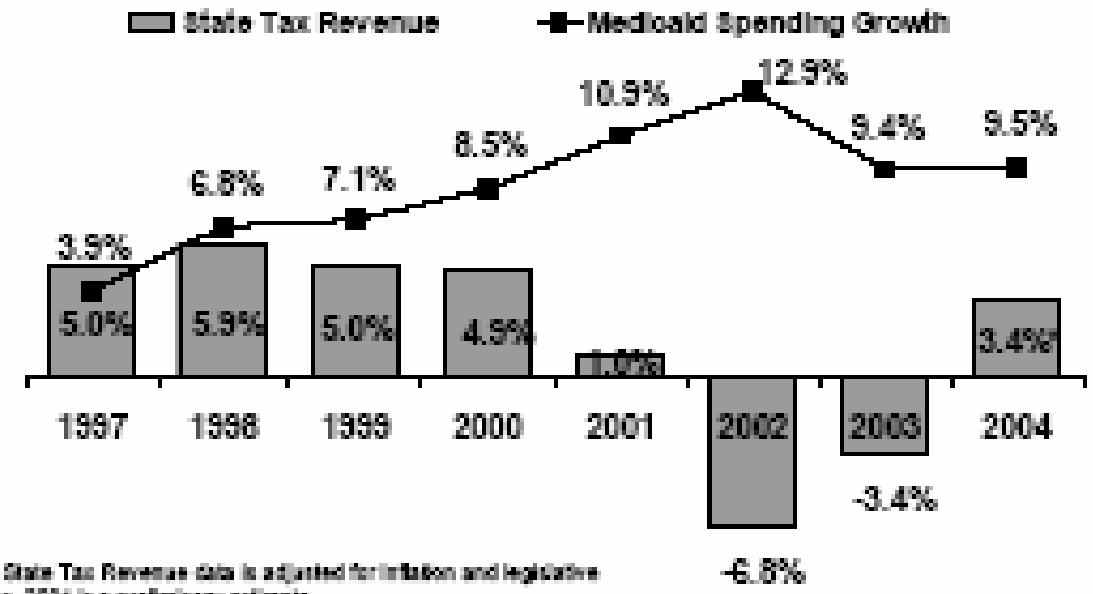
"States Struggle with Medicaid budgets"

Policy Tools Utilized by States

- PA, PDL, Supplemental rebates
- Reimbursement cuts
- Eligibility cuts
- Fixed rate contracts- managed care organizations
- Disease Management??
- *New-Recipient self purchased plan with fixed $ amount- Fla*

Figure 3

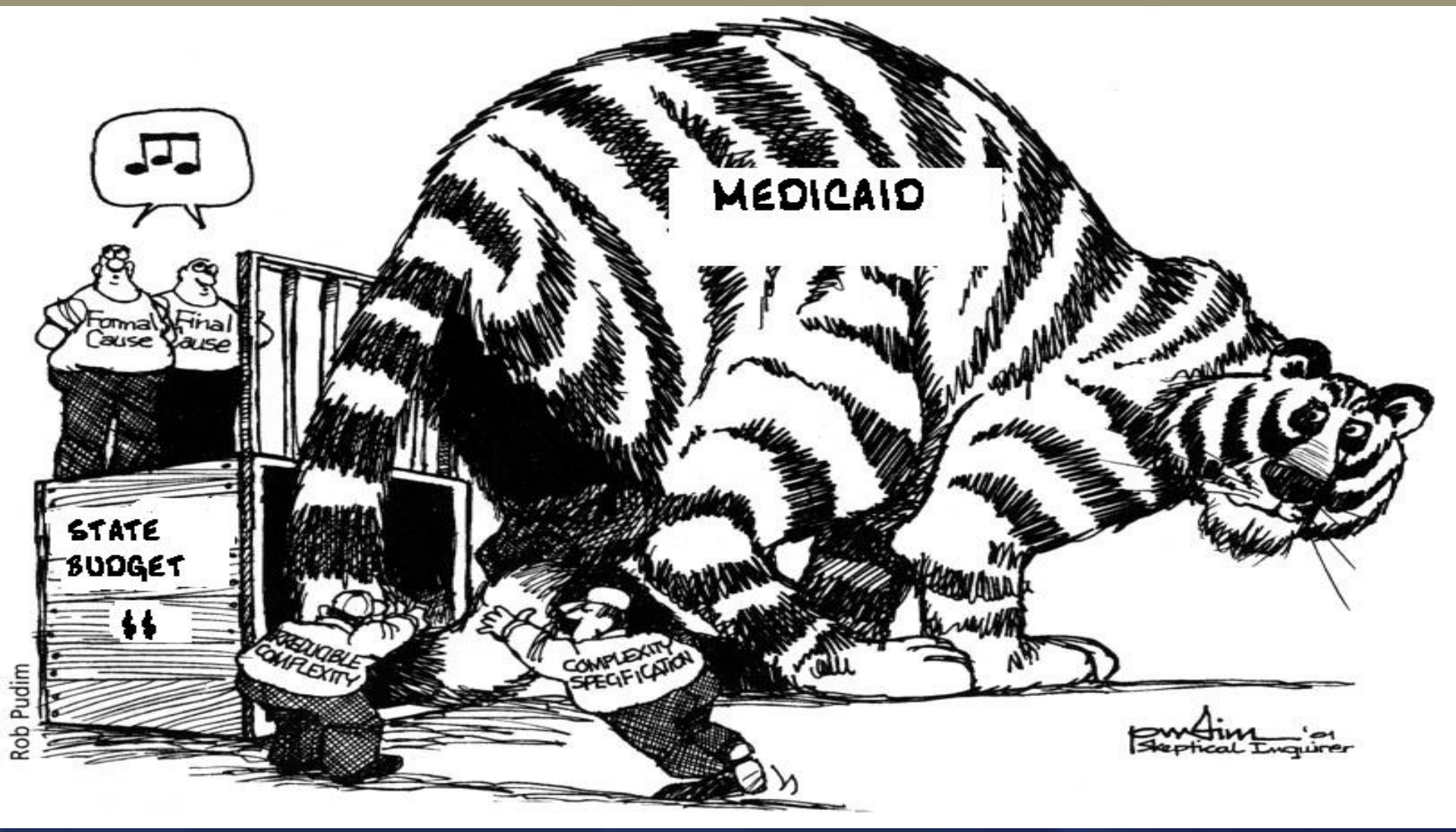
Underlying Growth in State Tax Revenue Compared with Average Medicaid Spending Growth, 1997-2004



NOTE: State Tax Revenue data is adjusted for inflation and legislative changes. 2004 is a preliminary estimate.

SOURCE: Analysis by the Rockefeller Institute of Government of data from the Bureau of the Census, Bureau of Economic Analysis and the National Association of State Budget Officers.

KAISER COMMISSION ON
Medicaid and the Uninsured


MEDICAID
Formal Cause
Final Cause
STATE BUDGET
$$
IRREDUCIBLE COMPLEXITY
COMPLEXITY SPECIFICATION
Rob Pudim
Skeptical Inquirer

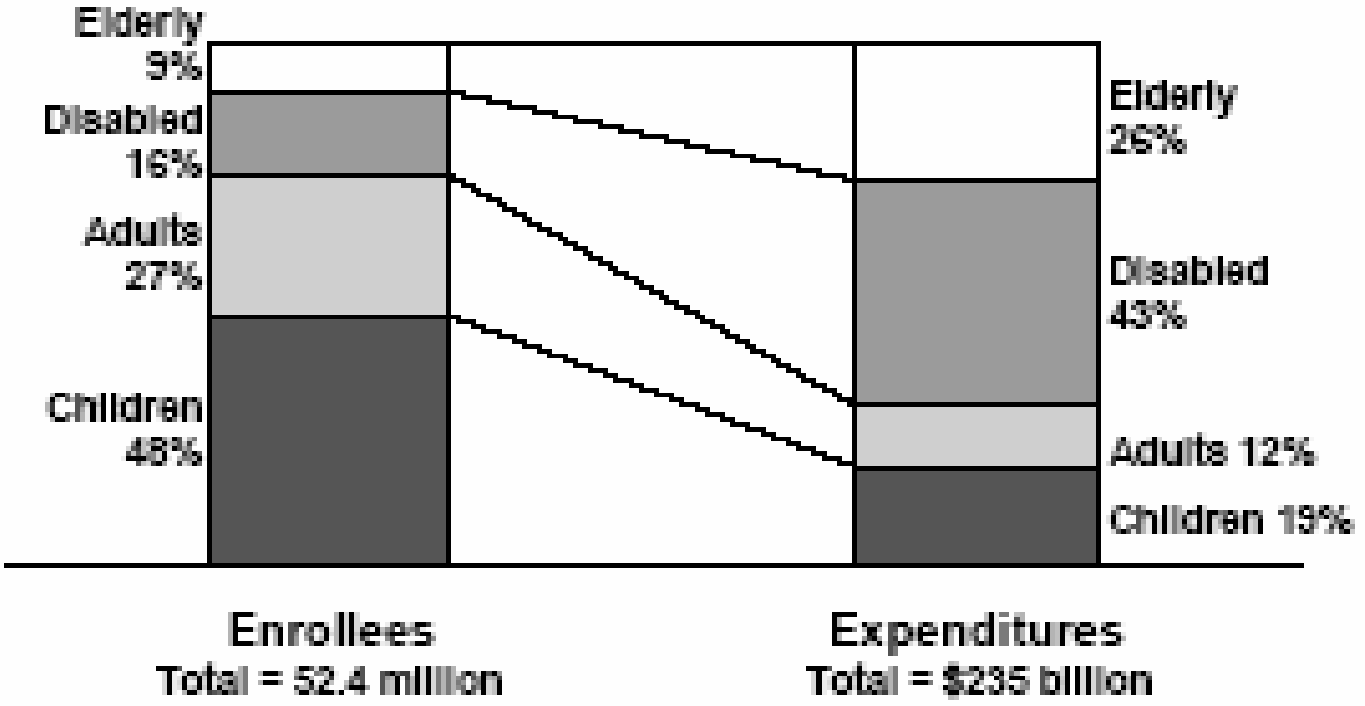
The Cost Equation

- Eligibility and benefit- who you cover and for what
- Reimbursement- what you pay
- Utilization- how much services are provided

We just have not figured out how to manage utilization!!!

Figure 7

Medicaid Enrollees and Expenditures by Enrollment Group, 2003



Expenditure distribution based on CBO data that includes only federal spending on services and excludes DSH, supplemental provider payments, vaccines for children, administration, and the temporary FMAP increase. Total expenditures assume a state share of 43% of total program spending.
SOURCE: Kaiser Commission estimates based on CBO and OMB data, 2004.

KAISER COMMISSION ON
Medicaid and the Uninsured

North Carolina Medicaid

- PCCM (Access I) started in 1992
- HMO contracted in 3 metro area 1997
- First (7) community networks (Access II/III) piloted 1998
- Most HMOs did not renew- 2001
- CCNC(Access II/III) became single Medicaid strategy 2002

Current NC Medicaid Facts

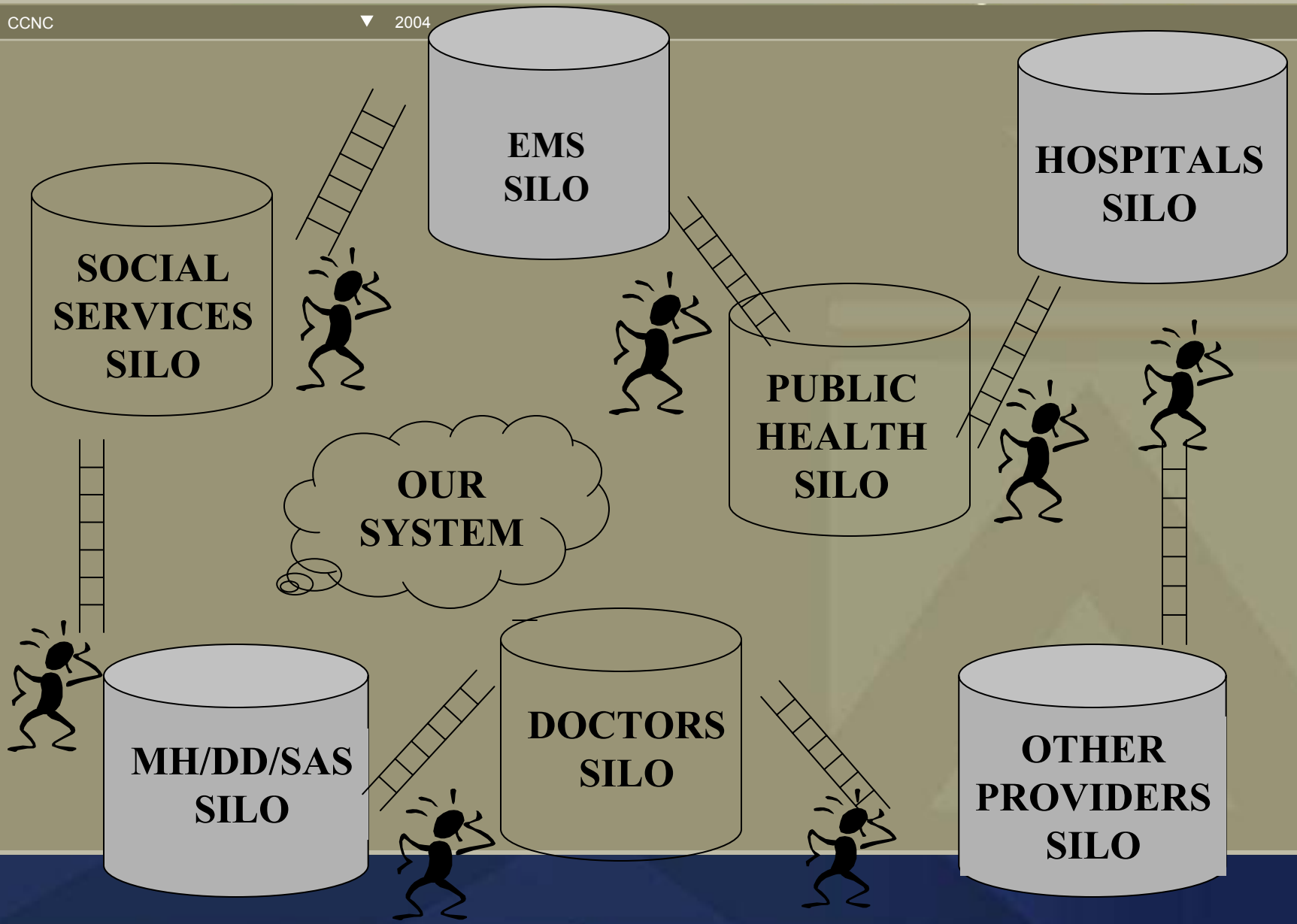
- 1.2 million covered (15.2% 0f population)
- 686,000 children covered
- 45% of all babies born covered
- 30.5 % of recipients consume 74.5% resources
- Drug cost now equals hospital cost was increasing at double digit rate yearly
- Inpatient care (hosp,NH,MRC) consumes 40.7%
- Physicians account for only 9-10% of costs!!!

ISSUES:

- No real care coordination system at the local level
- PCPs feel limited in their ability to manage care in the current system
- Local public health departments and area mental health programs are not coordinated into the medical care management process
- Duplication of services at the local level
- State “Silo Funding”

Issues(continued..)

- Only 1/3 of Medicaid budget is women and children. 2/3 disabled and elderly which is less suitable for typical commercial managed care approach
- Large portion of the state's Medicaid population is in rural counties where there is minimal managed care activity


EMS SILO
HOSPITALS SILO
SOCIAL SERVICES SILO
PUBLIC HEALTH SILO
OUR SYSTEM
MH/DD/SAS SILO
DOCTORS SILO
OTHER PROVIDERS SILO

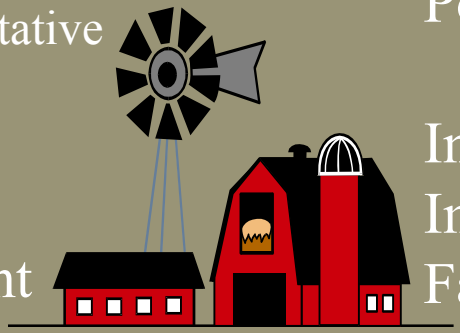
Silos Within Silos

Division of Social Services

Carolina Access MCR
(Managed Care Representative)

* Gathers & processes local enrollment data
* Interprets Access roles for the state
* Gathers local Medicaid statistics
* Patients & doctors representative

Medicaid Intake
Transportation
Work First/Job Placement
Child Protection Services
Adult Protection Services
Day Care
Child Support
Emergency Assistance
Food Stamps



Division of Public Health

Child Services Coordination
Maternity Care Coordination
Maternal Outreach Program
Health Check
Postpartum Newborn/ Nurse Home Visiting Program
Intensive Home Visitor Program
Immunization Program
Family Planning
WIC/Breast Feeding Promotion
Communicable Disease
Environmental Health
Health Promotions

Carolina Access I (10+ yr experience) The statewide PCCM has resulted in:

- Medicaid patients linked with a primary care provider increasing access to services across the state
- Primary care providers willing to serve as a gatekeepers and assist patients with appropriate utilization of the health care system($2.50pmpm)

IMPROVED ACCESS

The problem was that it did not address the population that consumed the most resources!!

Options consider for NC Medicaid

- State Operated
- Contracted Out
- Locally Run

Primary Goals

- *Improve the care of the Medicaid population while controlling costs*
- *Develop Community based networks capable of managing populations*

Basic Operating Premise

- Regardless of who manages Medicaid, the hospitals, physicians and safety net providers in NC serving patients remain the same and must be engaged
- We need to transform Medicaid management from a regulatory function to a health management function
- We must carefully balance cost containment with quality improvement efforts
- Decision making must be driven by data & outcomes monitored
- We must help transform healthcare system from acute care model to chronic illness model

"Management rather than Regulation"

Goals Achieved By:

- Making Sure People Get Care When They Need It
- Increasing local provider collaboration
- Obtaining Quality Care
- Implementing Best Practice Guidelines
- Managing Medicaid Costs

Community Care of North Carolina
Build on ACCESS I

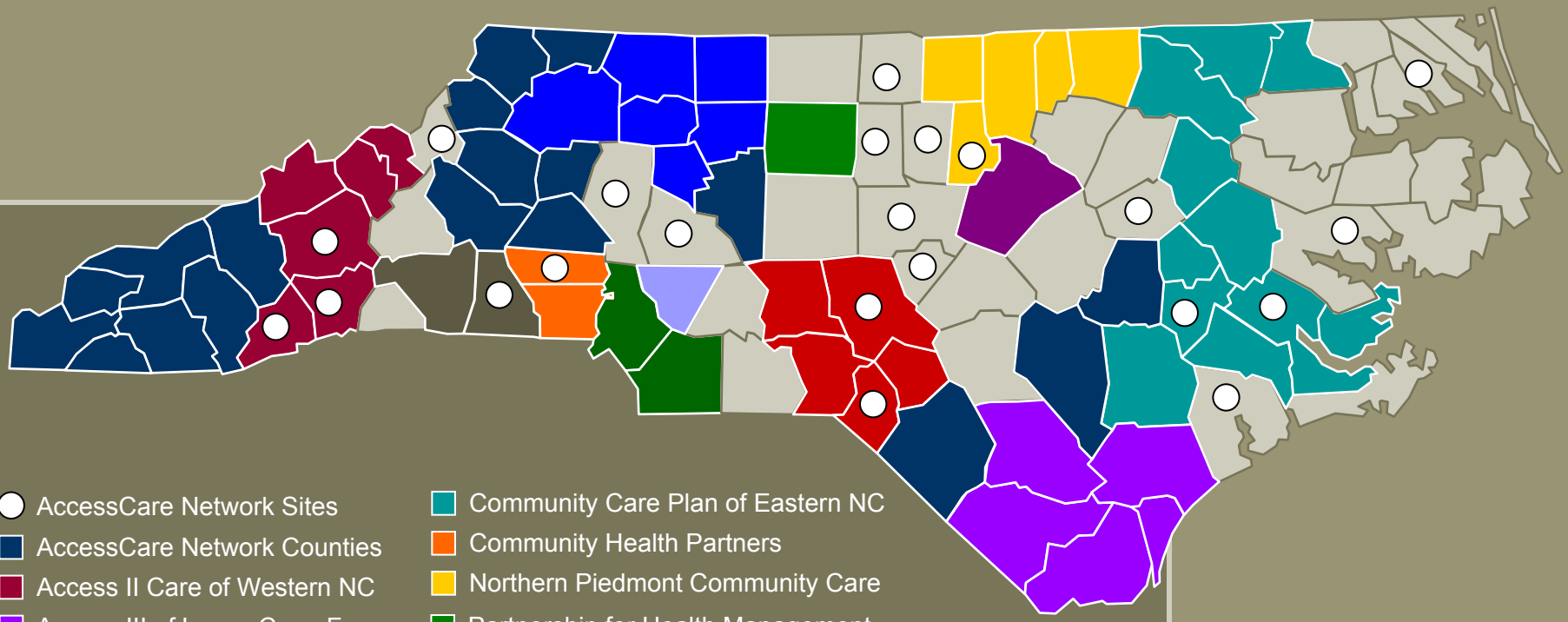
- Joins other community providers (hospitals, health departments and departments of social services) with physicians
- Creates community networks that assume responsibility for managing recipient care

Community Care of North Carolina

- Focuses on improved quality, utilization and cost effectiveness of chronic illness care
- 15 Networks with more than 3000 physicians
- 595,000 enrollees

Community Care of North Carolina

Access II and III Networks – 9/04



- AccessCare Network Sites
- AccessCare Network Counties
- Access II Care of Western NC
- Access III of Lower Cape Fear
- Cabarrus Community Care Plan
- Central Piedmont Access II
- Carolina Community Health Partnership
- Comm. Care Partners of Gtr. Mecklenburg
- Community Care Plan of Eastern NC
- Community Health Partners
- Northern Piedmont Community Care
- Partnership for Health Management
- Sandhills Community Care Network
- Wake County Access II

Community Care Networks:

- Non-profit organizations
- Includes all providers including safety net providers
- Steering/Governance committee
- Medical management committee
- Receive $2.50 PM/PM from the State
- Hire care managers/medical management staff

What Networks Do

- Assume responsibility for Medicaid recipients
- Identify costly patients and costly services
- Develop and implement plans to manage utilization and cost
- Create the local systems to improve care & reduce variability
- Implement improved care management and disease management systems

Key Program Areas in Managing Clinical Care:

- Implementing quality improvement — Best practice processes
- Implementing disease management
- Managing high-risk patients
- Managing high-cost services
- Building accountability through monitoring & reporting

Managing Clinical Care

I Clinical Directors Group

- Select targeted diseases/care processes
- Review evidenced-based practice guidelines
- Define the program
- Establish program measures

- ASTHMA
- DIABETES
- PHARMACY
- HIGH-RISK & -COST
- ED

II Local Medical Mgmt. Comm.

- Implement state-level initiatives
- Develop local improvement initiatives

- GASTRO-ENTERITIS
- OTITIS MEDIA
- CHILD DEVELOPMENT
- ADHD
- FEVER
- DEPRESSION
- LOW BIRTH WEIGHT
- ANCILLARY SERVICES

III PRACTICE A | **PRACTICE B** | **PRACTICE C**

Care Managers and Access II and III quality improvement staff support clinical management activities

Improving Quality
"*Disease Management*"

Current Disease Management Initiatives

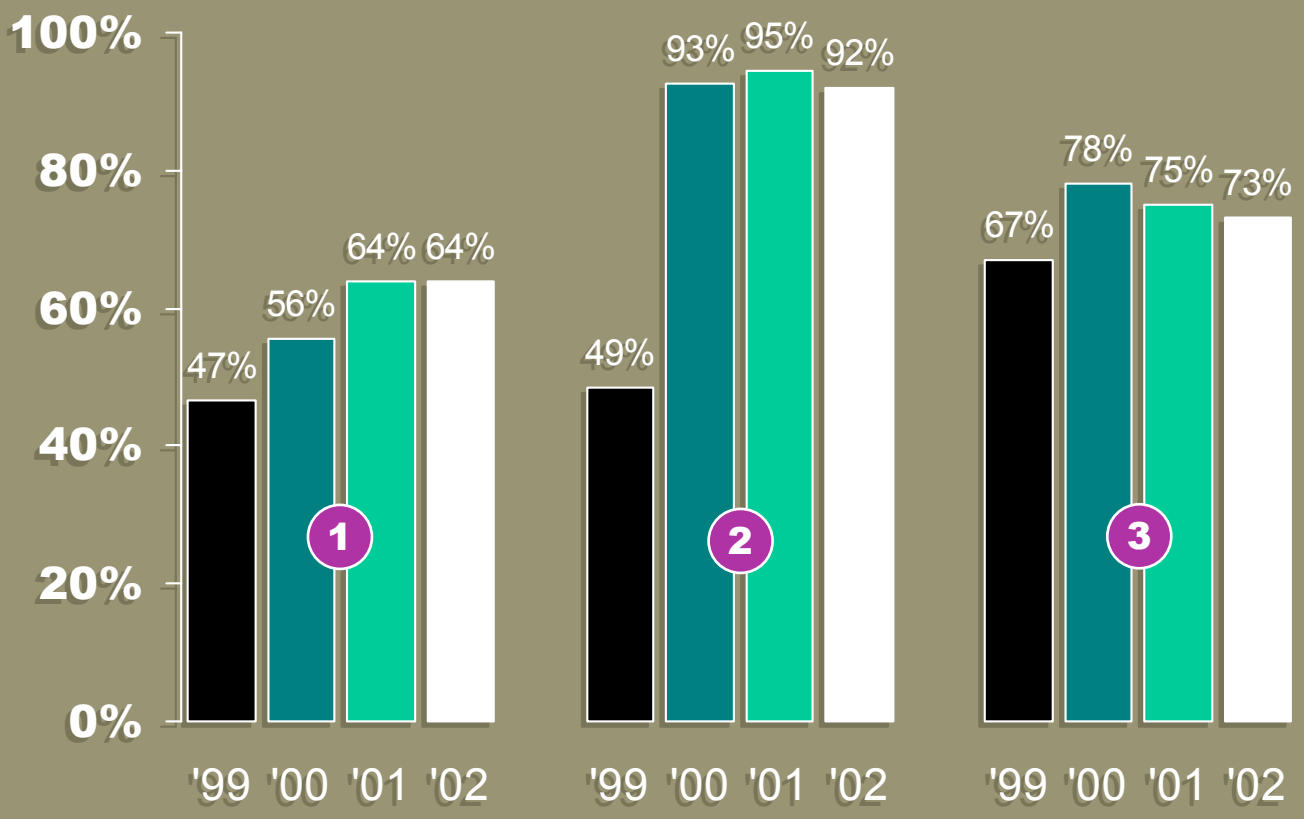
- Asthma
- Diabetes
- Pilots in Depression, ADHD, Special Needs Children, Gastroenteritis, Otitis Media and Low Birth Weight

Asthma Initiative

- First program initiative – began Jan. 1999
- Adopted best practice guidelines (NIH)
- Implemented continuous quality improvement processes at each practice
- Physicians set performance measures
- Provide regular monitoring and feedback

Asthma Initiative

Process Measures



Key

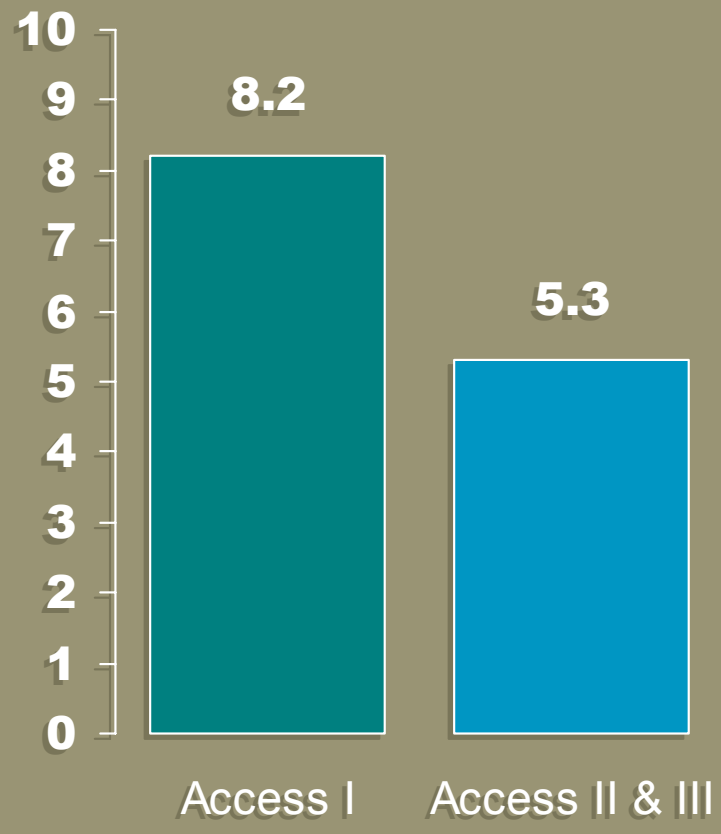
1. No. with asthma who had documentation of staging
2. No. staged II – IV on inhaled corticosteroids
3. No. staged II – IV who have an AAP

HOME
NEXT
LAST

Asthma Initiative

Pediatric Asthma Hospitalization Rates

April 2000 - December 2002



Key

In patient admission rate per 1000 member months

Asthma Pilot DM Findings from Sheps:

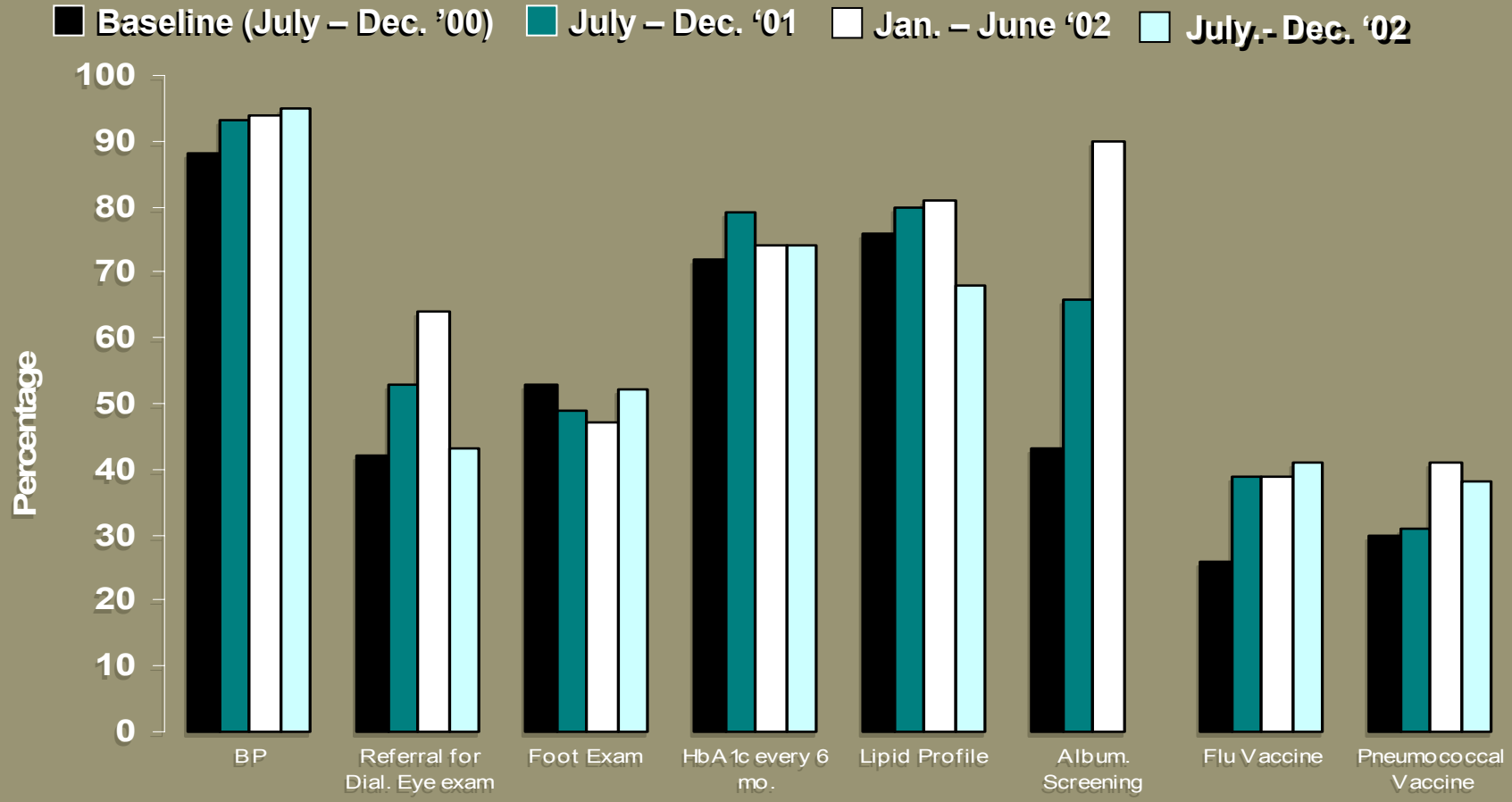
- CY 2000 Annual Savings $ 290,000
- CY 2001 Annual Savings $ 1,470,000
- CY 2002 Annual Savings $ 1,580,000

Diabetes Initiative

- Second program-wide initiative – began July 2000
- Adopted best practice guidelines (ADA)
- Implement continuous quality improvement processes at each practice
- Physicians set performance measures
- Provide regular monitoring and feedback

Diabetes Initiative

ACCESS II-III Diabetes Chart Audit Results



SOURCE: February 20, 2004 Sheps Center Report

Diabetes Disease Management Findings:

- Overall pmpm costs for CCNC diabetes lower than Access
- 9% lower hospital admissions

Diabetes DM Findings from Sheps:

- Cost savings for diabetes care for 3 year period approximately $2.1 million
- Potential > $11.3 million total savings in 2003 if CCNC were statewide with asthma and diabetes DM

Managing Costs
" Targeted Approach"

Managing High-Cost Services:

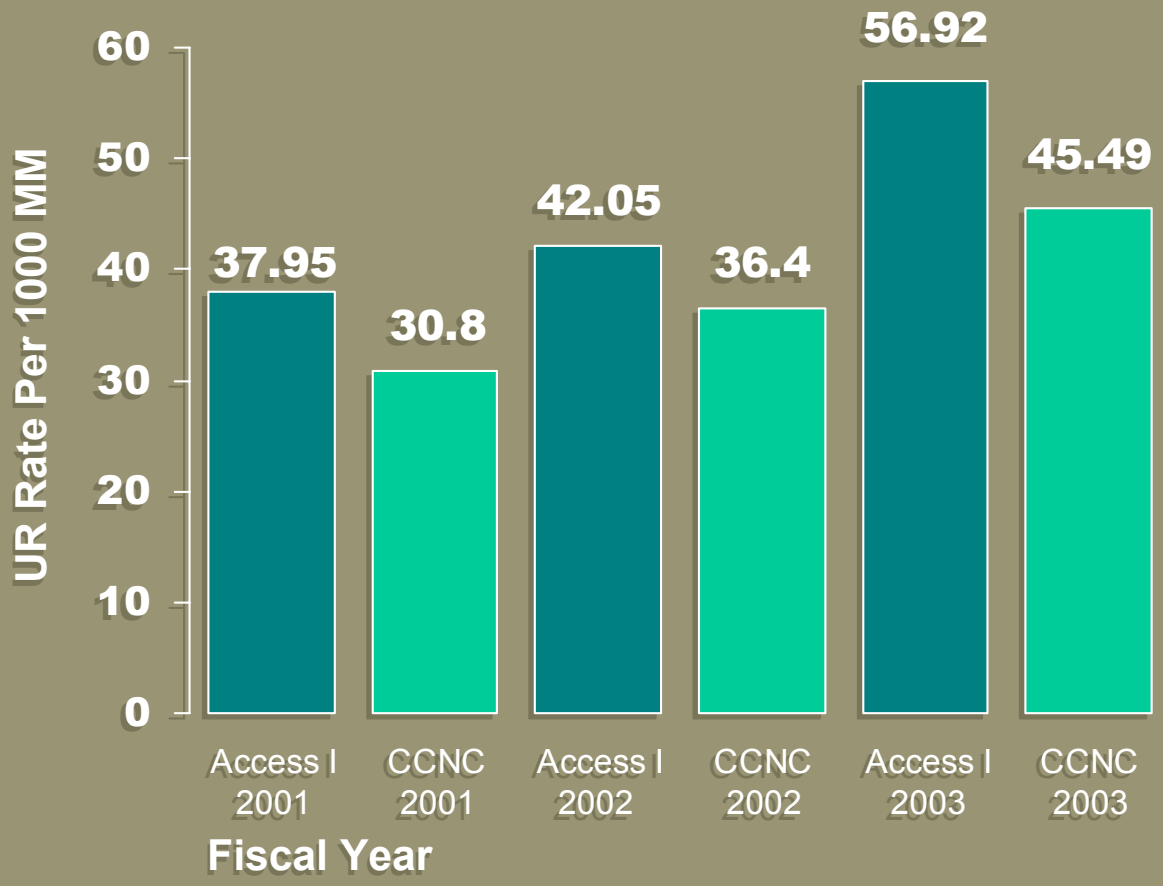
- Pharmacy
  - — Nursing home polypharmacy
  - — PAL
  - — Ambulatory polypharmacy
- Emergency Department
- Ancillary Services
- In-home Care

ED Initiative

- Target enrollees with 3 or more ED visits in 6 month time period
- Care managers perform outreach, education & follow-up
- Special mailings target top 3 reasons for ED visits (otitis media, fever, upper respiratory infections)
- Reinforce “medical home” concept

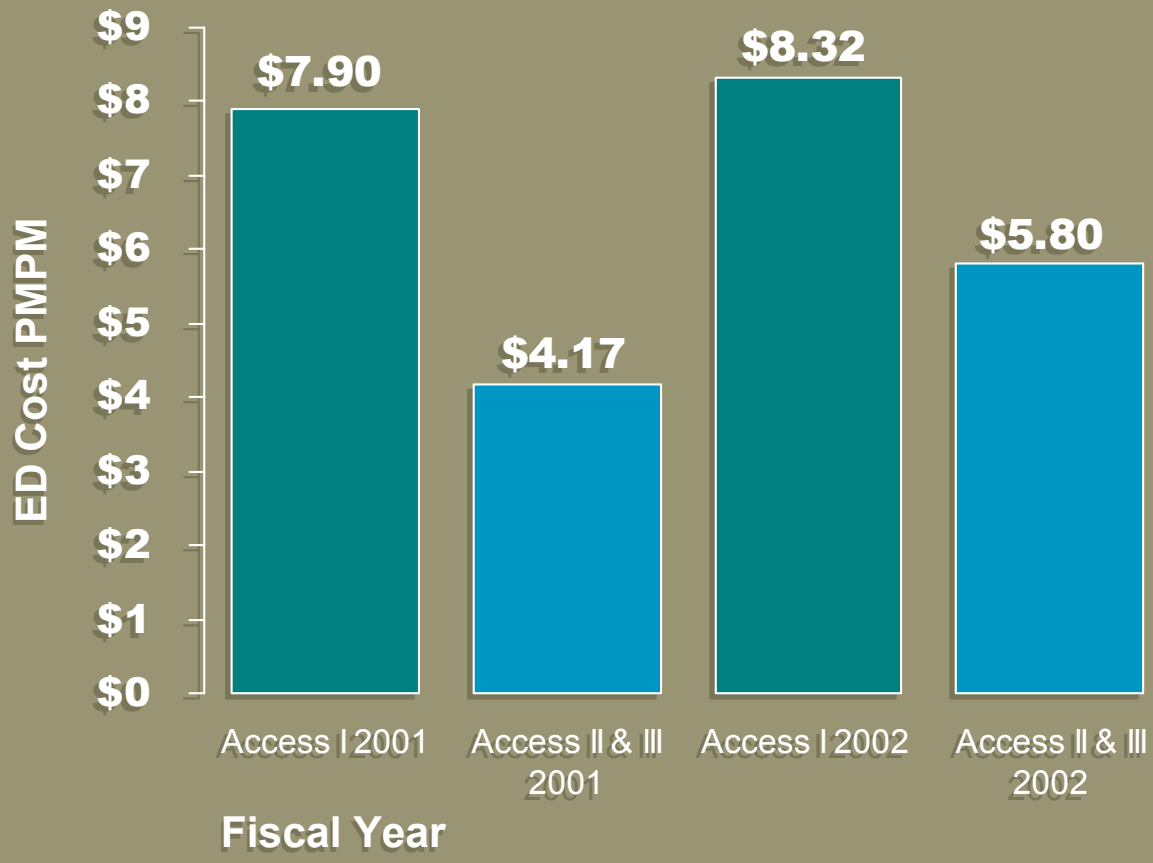
ED Initiative

ED Utilization Rate – 7/1/01 – 6/30/03 – Children < 21 years



ED Initiative

ED Cost PMPM – 7/1/01 – 6/30/02 – Children < 21 years



Savings Calculation

(Access I PMPM – Access II-III) x Access II-III Enrollment

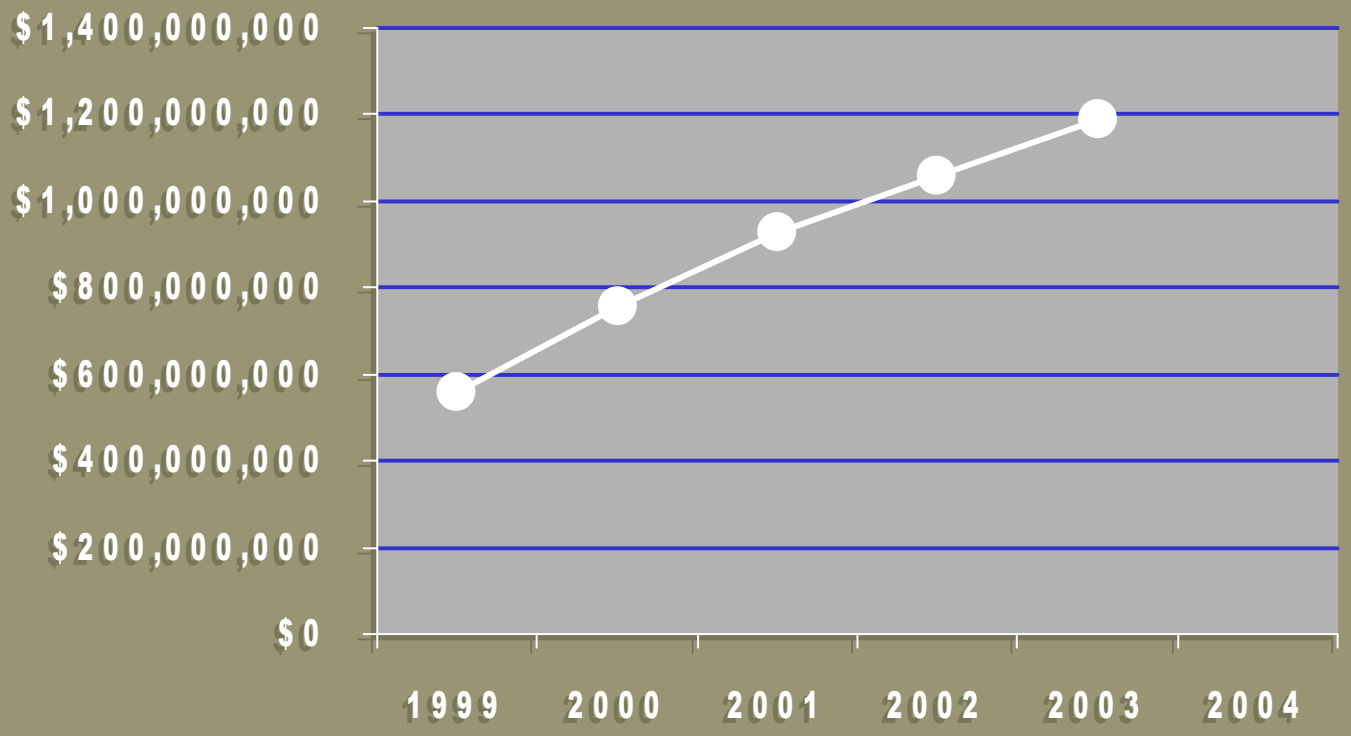
Total Savings – '01-'02
$10,362,190

HOME
NEXT
LAST

Cost Effective Prescribing 2003

"How to make a difference in rising prescription drug costs!"

NC Medicaid Expenditures: Prescription Drugs



FY99
$557,772,670

FY00
$754,505,194

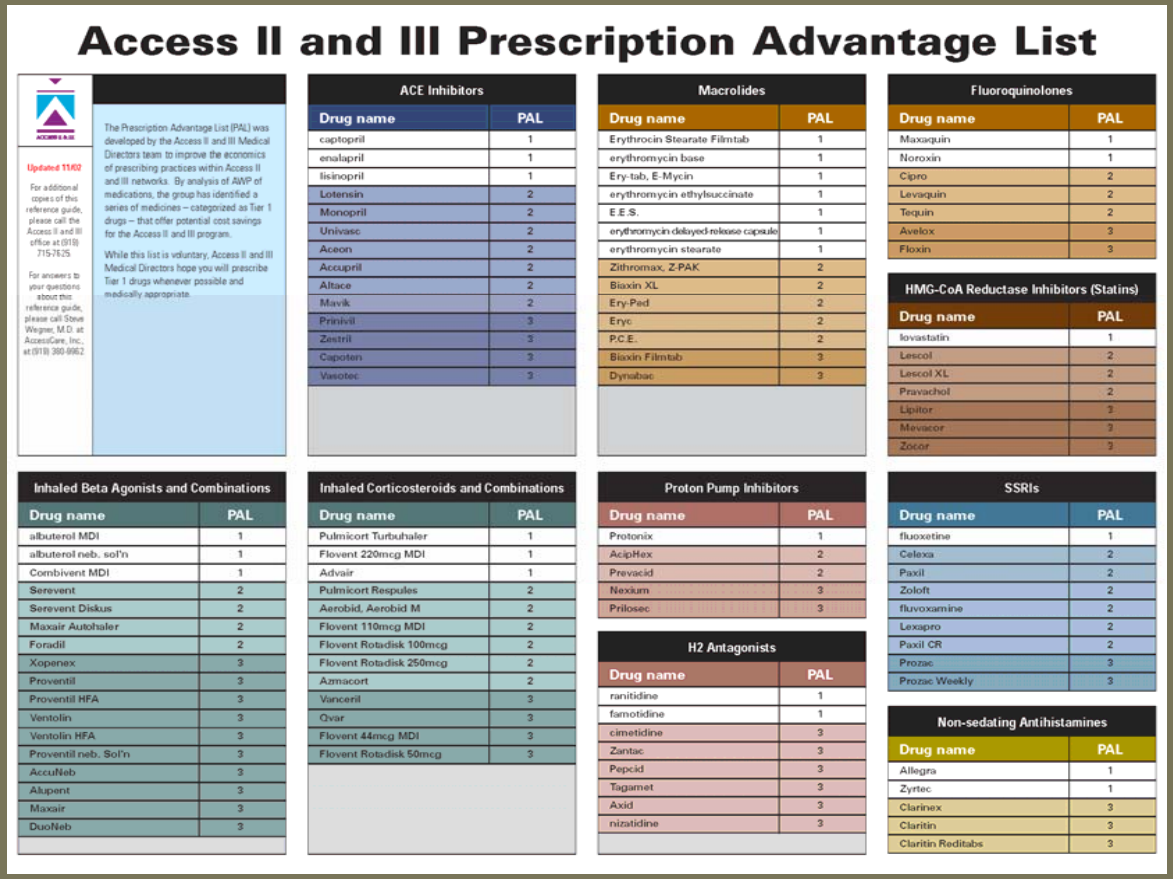
FY01
$927,240,693

FY02
$1,056.158.750

Process – PAL

- Pharmacy committee defines drug classes and unit doses
- Medicaid calculates relative drug cost and rank (net costs- includes rebates)
- Inform Access II and III physicians
- Measure changes in prescribing patterns
- State-wide rollout began Nov 2003

PAL — Prescription Advantage List



Access II and III Prescription Advantage List

Updated 11/02

For additional copies of this reference guide, please call the Access II and III office at (919) 715-7625.

For answers to your questions about this reference guide, please call Steve Wegner, M.D. at AccessCare, Inc., at (919) 380-9962.

The Prescription Advantage List (PAL) was developed by the Access II and III Medical Directors team to improve the economics of prescribing practices within Access II and III networks. By analysis of AWP of medications, the group has identified a series of medicines – categorized as Tier 1 drugs – that offer potential cost savings for the Access II and III program.

While this list is voluntary, Access II and III Medical Directors hope you will prescribe Tier 1 drugs whenever possible and medically appropriate.

ACE Inhibitors

Drug name	PAL
captopril	1
enalapril	1
lisinopril	1
Lotensin	2
Monopril	2
Univasc	2
Aceon	2
Accupril	2
Altace	2
Mavik	2
Prinivil	3
Zestril	3
Capoten	3
Vasotec	3

Macrolides

Drug name	PAL
Erythrocin Stearate Filmtab	1
erythromycin base	1
Ery-tab, E-Mycin	1
erythromycin ethylsuccinate	1
E.E.S.	1
erythromycin delayed-release capsule	1
erythromycin stearate	1
Zithromax, Z-PAK	2
Biaxin XL	2
Ery-Ped	2
Eryc	2
P.C.E.	2
Biaxin Filmtab	3
Dynabac	3

Fluoroquinolones

Drug name	PAL
Maxaquin	1
Noroxin	1
Cipro	2
Levaquin	2
Tequin	2
Avelox	3
Floxin	3

HMG-CoA Reductase Inhibitors (Statins)

Drug name	PAL
lovastatin	1
Lescol	2
Lescol XL	2
Pravachol	2
Lipitor	3
Mevacor	3
Zocor	3

Inhaled Beta Agonists and Combinations

Drug name	PAL
albuterol MDI	1
albuterol neb. sol'n	1
Combivent MDI	1
Serevent	2
Serevent Diskus	2
Maxair Autohaler	2
Foradil	2
Xopenex	3
Proventil	3
Proventil HFA	3
Ventolin	3
Ventolin HFA	3
Proventil neb. Sol'n	3
AccuNeb	3
Alupent	3
Maxair	3
DuoNeb	3

Inhaled Corticosteroids and Combinations

Drug name	PAL
Pulmicort Turbuhaler	1
Flovent 220mcg MDI	1
Advair	1
Pulmicort Respules	2
Aerobid, Aerobid M	2
Flovent 110mcg MDI	2
Flovent Rotadisk 100mcg	2
Flovent Rotadisk 250mcg	2
Azmacort	2
Vanceril	3
Qvar	3
Flovent 44mcg MDI	3
Flovent Rotadisk 50mcg	3

Proton Pump Inhibitors

Drug name	PAL
Protonix	1
AcipHex	2
Prevacid	2
Nexium	3
Prilosec	3

H2 Antagonists

Drug name	PAL
ranitidine	1
famotidine	1
cimetidine	3
Zantac	3
Pepcid	3
Tagamet	3
Axid	3
nizatidine	3

SSRIs

Drug name	PAL
fluoxetine	1
Celexa	2
Paxil	2
Zoloft	2
fluvoxamine	2
Lexapro	2
Paxil CR	2
Prozac	3
Prozac Weekly	3

Non-sedating Antihistamines

Drug name	PAL
Allegra	1
Zyrtec	1
Clarinex	3
Claritin	3
Claritin Reditabs	3

Anticipated Savings

- PAL- $ 30 -40 million annual savings expected
- Other Pharmacy Management/Policy Initiatives:

  Selected Prior Approval

  Specialty Disease Registry

  Active Intervention

  Selected OTC coverage

Nursing Home Polypharmacy Initiative (“Active Intervention”)

Community Care of North Carolina

Intervention

Pharmacist / Physician Teams

- Review drug profiles / medical records of Medicaid patients in nursing homes
- Determine if a drug therapy problem exists
- Recommend a change
- Perform follow-up to determine if change was made

Screening Criteria

- Nursing home residents with . . .
  - >18 drugs used in a 90 day period
- 9208 residents met this criteria
- Medicaid database uses criteria to flag charts

Flagging Criteria

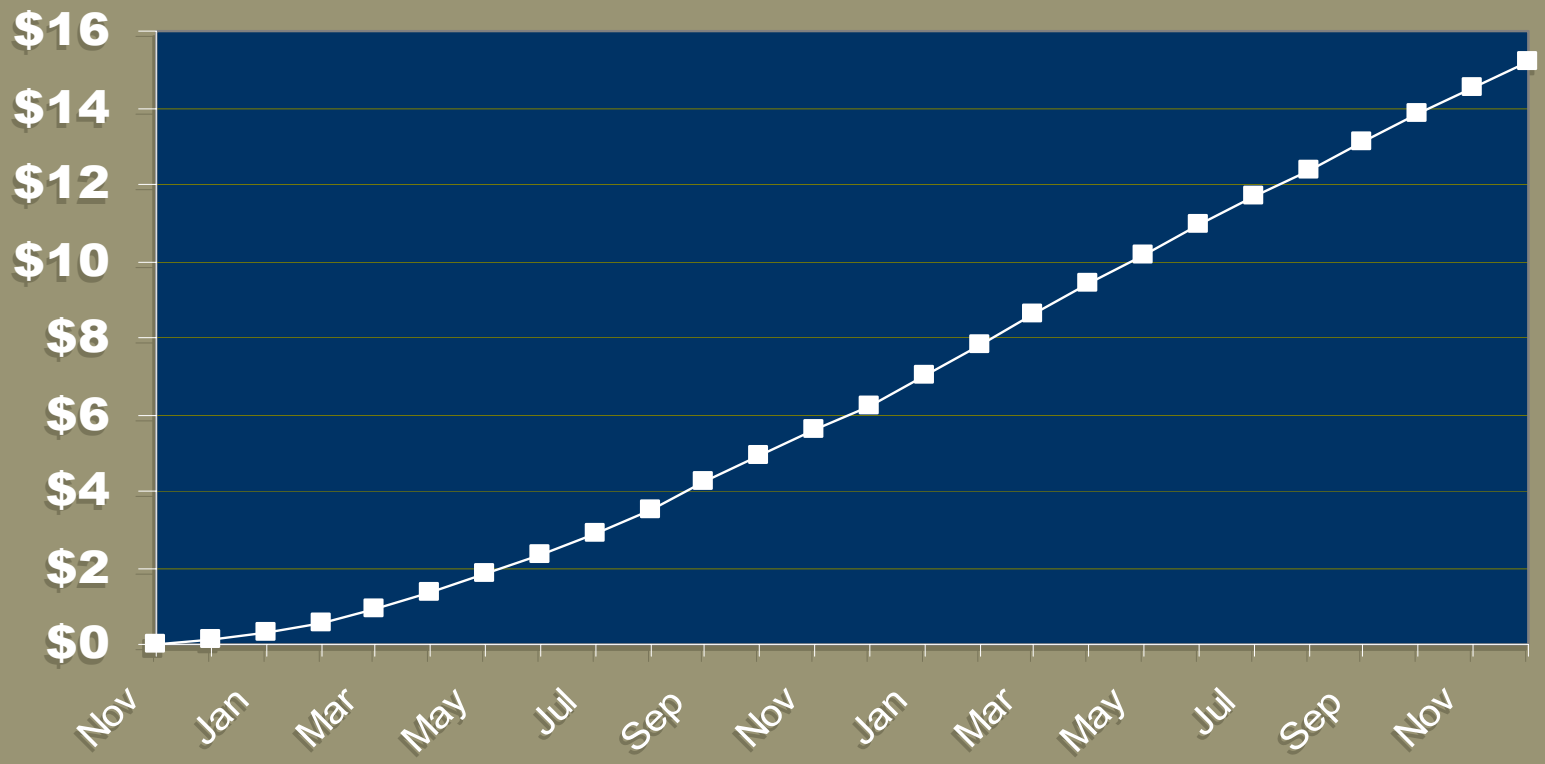
- Inappropriate Rx for the elderly “Beers drugs”
- Drugs used beyond usual time limit
- Drug Use Warnings & precautions
- Prescription Advantage List “PAL”
- Potential Therapeutic Duplication

Preliminary Findings

- Patients reviewed: 9208
- Recommendations made: 8559
  - Unnecessary therapy – 19%
  - More cost effective drug – 56%
  - Wrong dose – 7%
  - Potential adverse reaction – 9%
  - Needs additional therapy – 3%
  - Other – 6%
- Recommendations implemented: 6359 (74%)

Potential Cumulative Savings from Interventions

Dollars in Millions



Cost/Benefit Estimates

Community Care of North Carolina

July 1, 2002 – Jun 30, 2003

- Cost - $8.1 Million

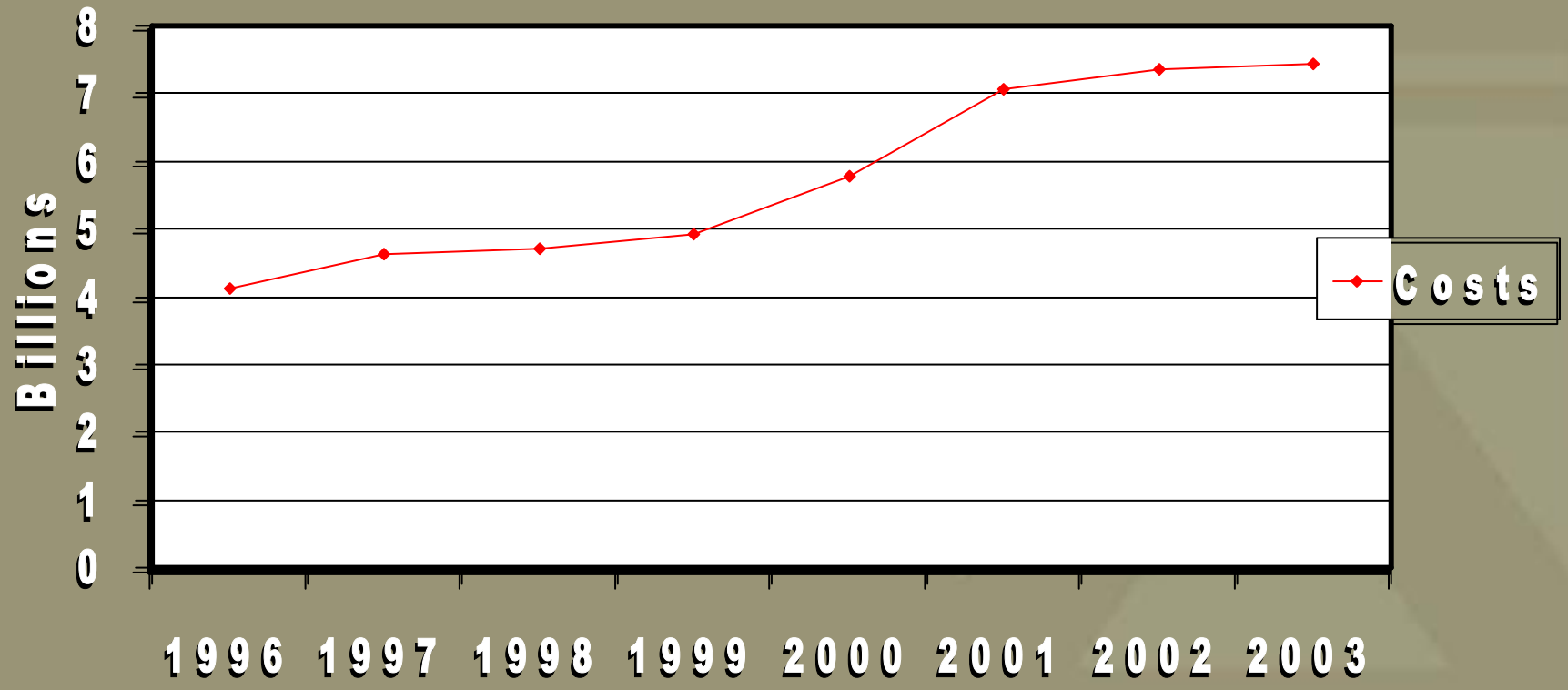
  (Cost of Community Care operation)

- **Savings - $60,182,128 compared to FY02**

- **Savings- $203,423,814 compared to FFS**

  (Mercer Cost Effectiveness Analysis – AFDC only for Inpatient, Outpatient, ED, Physician Services, Pharmacy, Administrative Costs, Other)

NC Medicaid Expenditures



Pilot Initiatives

- Therapy services
- Low birth weight
- Disparities
- Mental health integration
- Poly-pharmacy in outpatient settings
- Sickle cell
- **Community Access programs (uninsured)**
- Special needs population

Big Lessons & Challenges

- There are no easy $ 100 million decisions- but there may be 50 $ 2million decisions (you just have to find them)
- Providers must be engaged- but a challenge to keep their attention
- Must make policy decisions consistent with program goals and vision
- Savings are additive (the total sum of savings seem to be greater than the sum of individual initiatives)

Other Lessons Learned

1. Top down approach is not effective in N.C.
2. Community ownership a must
3. Can't do it alone - must partner
4. Incentives must be aligned
5. Must develop systems that change behavior at the practice and community level
6. Have to be able to measure outcomes (data and feedback important- "you get what you inspect…")
7. Lasting change takes time and reinforcement
8. There are indirect quality and cost benefits to the community

Community Care of North Carolina

Thank You

HOME